every person consulting the doctor, or seven for every ten consultations. At least one certificate was given for every 4.5 consultations, and only about half of them were for official purposes. Referrals were at the rate of 35 per 100 persons in the year, and most of these patients were referred only once. The elderly male patients with a referral rate of 57 per 100 persons were referred most often.

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REFERENCES

Backett, E. M., Shaw, L. A., and Evans, J. C. G. (1953). *Proc. roy. Soc. Med.*, **46**, 707.
Fry, J. (1952). *British Medical Journal*, **2**, 249.
Hill, A. Bradford (1951). *J. roy. statist. Soc.*, **114**, 1.
McGregor, R. M. (1950). *Edinb. med. J.*, **57**, 433.
McKinlay, P. L. (1950). Health Bulletin of the Department of Health for Scotland, **8**, 9.
Pemberton, J. (1949). *British Medical Journal*, **1**, 306.

TRAINING GENERAL PRACTITIONERS IN PSYCHOTHERAPY

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Present Situation Regarding Psychotherapy in General Practice

It is generally agreed that at least one-quarter of the work of the general practitioner consists of psychotherapy pure and simple. Some investigators put the figure at 50%, or even higher; but, whatever the figure may be, the fact remains that the present medical training does not properly equip the practitioner for at least one-quarter of the work he will have to do.

Although the need for a better understanding of psychological problems and for more therapeutic skill is keenly felt by many practitioners, they are reluctant to accept professional responsibility in this direction. The most frequent reason advanced is that they have too much to do and it is quite impossible for them to sit down and talk with one patient for an hour at a time, week after week. Impressive as it sounds, this argument is not, in fact, firmly based. It is true that establishing and maintaining a proper therapeutic relation needs much more time than prescribing a bottle of medicine. In the long run, however, it can lead in many cases to a considerable saving of time both for the doctor and for his patient (and for the National Health Service). In the Appendix two cases are quoted to prove this point.

What actually happens at present in most of the so-called psychological cases of general practice is an almost mechanical prescribing of phenobarbitone if the patient is not depressed, and of some "tonic" if he is. If this fails, various specialists are consulted, usually resulting in "reassuring" reports that nothing organically wrong has been found. Eventually a psychiatrist is also consulted, often not so much as a deliberate policy as *faute de mieux*. This situation, however, is created as much by the difficulties of the psychiatrist as by those confronting the general practitioner. It is common knowledge that the psychiatric services are pathetically unequal to the ever-increasing demand; they are flooded with patients, and consequently the psychiatrist must pick and choose. If a patient is picked he is put on the waiting-list, eventually taken on for treatment, and, more often than not, lost completely to the practitioner. If the patient is not picked the report sent to the doctor hardly ever helps him in his psychotherapeutic task except advising him to give sedatives *or* tonic.

Thrown back on his own resources, the doctor, often shamefacedly, prescribes some placebo or gives a "reassuring" pep talk. (It is a common joke to ask, "Reassuring—but to whom?") Then there are the advocates of common-sense psychology who advise the patient to have a holiday, to change his job, to pull himself together, to leave home, to get married, to have a child or not to have any more children but use some contraceptives, etc. None of these recommendations is necessarily wrong, but the fallacy behind them is the belief that an experienced doctor has acquired enough well-proved "common-sense" psychology to enable him to deal with the psychological problems of his patients. But minor surgery, for instance, does not mean that a doctor can pick up a well-proved carving-knife or a common-sense carpentry tool and perform minor operations. On the contrary, he has to observe very carefully the rules of antisepsis and asepsis, he must know in considerable detail the technique of local and general anaesthesia, and must have acquired reliable skill in using scalpel, forceps, and needle, the tools of the professional surgeon. Exactly the same is true of psychotherapy in general practice. The uses of empirical methods acquired from everyday life are as limited in professional psychotherapy as are carving-knife and screw-driver in surgery.

Experiences in Teaching Psychotherapy to General Practitioners

In the past twenty-five years or so, psychiatrists in many countries have run courses for general practitioners, courses which were often arranged because of the pressing and ever-increasing demand for them.

The results of these courses have been generally disappointing. This is a surprising outcome, for the general practitioner of some years' standing is a very good trainee. He has had time to assess the value and limitations of what he has learnt at his medical school and hospital, he has also had a fair amount of frustration and success in his practice, and he has seen enough of human suffering to make him sensitive. (Seen from this angle general practitioners are much better material for training in psychotherapy than young medical students.) The reason for the failure of these courses would appear to be that theoretical lectures, even when based on, or illustrated by, case histories or clinical demonstrations, hardly give more to the general practitioner than what he can get from reading books. Strongly influenced by the traditional medical training based on lectures and clinical demonstrations, both practitioners and psychiatrists forget, in a mutually attractive teacher–pupil relation, that psychotherapy means acquiring a new skill and not learning some more theories and facts. Nothing is easier or more satisfying for a psychiatrist than to take a patient's case and deliver a lecture about the theoretical implications, the unconscious dynamisms, and the likely diagnosis of the patient. Moreover, such teaching is gratifying indeed to both. The

specialist can shine, and the practitioner feels enriched and reassured. But this gratifying collusion is disappointing in the long run because in reality it is too facile and does not give the means of effecting therapeutic changes.

Instead of allowing this teaching-being-taught atmosphere to develop, the aim of such a course should be to help the practitioner to acquire a new skill. This means a considerable, though limited, change in the personality of the doctor. The doctor has to discover in himself an ability to listen to things in his patients that are barely said, and, in consequence, he will start listening to the same kind of language in himself. This fairly difficult change of attitude is not needed if the doctor does not have to do the listening himself, but is taught and told what other people have found out about the "human mind"—namely, the theories of psychodynamics, of personality development, of transference patterns, and so on. In the same way as a new physical skill can be learnt only in the actual situation while dealing with the problems in it, so is it with the acquisition of a psychological skill. This is why concentrated full-time courses lasting for some weeks have proved to be of very limited value. The general practitioner must use his own current experience as a basis for learning the new skill. Past experiences are unsatisfactory for this purpose, since the memory of an emotional involvement is always less alive, less vivid, than the actual experience itself.

So far, so good; but the skill to be acquired involves understanding and guiding the development of the two-person (patient–doctor) relation, and the presence of a third person would fundamentally change this situation. This condition automatically excludes the presence of the tutor. Therefore the material on which the whole training has to be based is the doctor's report of what happened in the interview situation between him and his patient. This necessary condition implies a number of uncertainties. The doctor has not yet learnt what to look for and he is somewhat self-conscious and apprehensive because of his lack of skill and understanding; like everyone else, he too is apprehensive of criticism, and, consciously or unconsciously, tries to make his activities appear in the best light and to minimize his shortcomings and mistakes. On the other hand, in order to train him, his blind spots, shortcomings, and mistakes have to be brought out quite clearly and discussed as frankly as possible. It is difficult enough to do this in any sphere of physical activity which is near to the core of the personality—say, for instance, in dancing, social behaviour, or table manners—but it is still more difficult in the psychological sphere, where the whole personality is always involved. Moreover, any such personality change needs time, and it is impossible to hurry it. The only training which systematically caters for these difficulties is the psycho-analytic training, which provides for a personal analysis lasting for many years and amounting to several hundred hours.

Experience at the Tavistock Clinic, where courses in psychotherapy for general practitioners have been given for more than twenty years, has confirmed the limited value of "teaching" psychotherapy. Consequently in the last few years a new approach has been tried—namely, to shift the emphasis from "teaching" to training, using group methods to achieve to a certain extent, although admittedly not completely, the necessary changes in personal attitudes.

At first the aim was a very modest one, amounting only to the awakening of an awareness of psychological factors, enabling the practitioners to give a better and deeper assessment of their patients' problems and illnesses. According to the doctors' reports, the result has been a great saving of their time, much less need for complicated hospital examinations (hence a considerable saving for the National Health Service), and, last but not least, some help to the patients. Admittedly all this amounted only to something of a better diagnostic skill. But, having achieved a better diagnostic skill, the practitioners then wished to know how to treat the patients. This demand was not unexpected, as, with a greater awareness of the problems, the practitioners' desire to do something to alleviate them was bound to follow. To answer this demand a two-year course in psychotherapy was organized. I now report briefly on the principles and methods used in this course. My main reason for doing so at this stage is that I believe similar courses may be contemplated elsewhere, and I felt that the approach developed may be of value to others and an exchange of ideas about the problems involved would improve the quality of the work.

Training in Psychotherapeutic Skill: (a) First Attempts

We started by advertising "introductory courses in psychotherapy for general practitioners" in the medical press, and every practitioner interested was admitted to one of the courses, each taking in, on an average, 8 to 12 doctors. Each course lasted for a term and consisted of weekly case conferences of two hours each. No systematic theory was given. The practitioners were asked from the start to describe any recent "psychological case" they had had to treat, and the discussion was kept so far as possible concrete—that is dealing with the individual problems of the patients in question. For some doctors this was enough; one or two dropped out during, and a few more at the end of, the first term. The remainder were the ones—mentioned above—who asked for more. To provide this further training, the weekly case conferences were continued, but each conference session was now followed by a tutorial meeting on the general outlines of psychodynamics, based mainly on psycho-analytic concepts. Both events took place on the same afternoon, and lasted from 2 to 5 or 5.30. This arrangement continued for two terms, and as the demand for still more training persisted it was decided to institute a two-year course.*

The method used in our training scheme was developed and tested to a fair degree jointly by Enid Balint and myself while training for the Family Discussion Bureaux a group of social case-workers who were trying to help people with marital problems. The human problems facing these workers were roughly the same as, although in some relevant points simpler than, those of the general practitioners. Some of the similarities were the starting situation—namely, a patient in trouble coming for help and a professional offering understanding, the developing patient–doctor or patient–worker relation, especially the need for controlling the doctor's or worker's subjective involvement in this relation, and so on. What was different was the usual presence of illness, often physical, in the doctor's material, and the all-important fact that the general practitioner cannot "pass the buck." Unlike general practitioners, social workers and, for that matter, specialists may say—and as is well known they often do say—this or that patient is not "my cup of tea"; "I am not interested in this kind of illness"; "I cannot find any justification for his complaints"; "the illness is so slight, or so severe, or so progressed, that it is a waste of my time to treat the man"; "give him some reassurance and ½ gr. phenobarbitone thrice daily and leave me alone"; etc. The general practitioner, come what may, *must* see his patient through, sometimes even to the bitter end; he cannot "refer him back" with an easy and empty cliché.

Before describing our scheme I wish to discuss at some length the implications for training of this factor, as its realization profoundly influenced our attitude.

(b) Practitioners and Their Relation to Specialists

The first of these implications is that the general practitioner must remain in his practice during his whole training. This rightly emphasizes the mutual roles of the psychiatrists on the one hand and the practitioners on the

*In fact, our total intake was 36 doctors. Of these, seven were irregular attenders right from the start. Of the regulars nine left after their first and a further five after their second term, leaving 15 who are doing the present two-year course.

other. Both of them are doing their jobs, neither of them is so important that for his sake the other must make sacrifices; their jobs and their roles are those of peers. A further consequence is that the general practitioner remains in full and unrestricted control of his patients, he is the one who is running the show; the psychiatrist accepts the fact that his own role is that of an expert assistant, not that of a manager, and still less of a superior mentor or teacher.

Although this approach preserves, even enhances, the practitioner's dignity, it is only with great difficulty that it can be accepted by him. One reason is the burden of responsibility, sometimes really severe, that it involves. It is so much easier to farm out responsibility, to say, "I have asked all the important specialists and none of them could say anything of importance; I really need not be better than the bigwigs." No such escape is permitted in our course. Although the opinions of specialists are asked for and listened to, they are not accepted as final or binding; they are criticized for what they are worth, and then the doctor in charge is asked to decide what is to be done with the patient and to accept undivided and unmitigated responsibility for his decision. Often the decision influences the patient's whole future. This fact too must be borne in mind.

No wonder that the practitioners, as often as not, do not like to shoulder this heavy burden. What is more surprising is the willingness of the psychiatrists (in fact of all specialists) to enter into a collusion with the general practitioner in order that this responsibility may be dissipated, if I may say so, into thin air. The patient with psychological complications is often seen by several "eminent" people, each of whom gives his opinion about one or other part of the problem, but the final responsible decision is seldom explicitly stated even if it has to be taken. If possible no decision is taken; things are left hanging until fateful events supervene and make the decision anonymously, allowing everybody to feel that after all it was not his word that counted. On the other hand, if things turn out well everybody concerned may feel that his contribution was highly important, if not the decisive one.

One feature of our scheme was to unmask this anonymity by making the practitioner accept that he is and must remain in charge of his patient. If the doctor needed more help than the course could give him he was free to refer his patient to the clinic for consultation only. The patient was then tested by a psychologist and interviewed by a psychiatrist (usually the leader of the course), but only if the doctor was willing to continue the treatment. The results of the tests and of the psychiatric interview were then brought up in our conferences and mercilessly scrutinized. The final test of their value, which kept psychologist and psychiatrist equally on their toes, was the standard question of how much help in his further treatment of the patient did the doctor get from their reports.

This is a severe test indeed, as I can testify from first-hand experience. Neither I nor the psychologists who took part in this scheme found it easy to accept that some of our reports were merely nice phrases, repeating in a different form the facts known only too well to the doctor, and giving him hardly any help in his difficult task. This sobering realization of the shortcomings of our work is only one of the many lessons that general practitioners can teach us specialists.

The "collusion" and anonymity mentioned above is an excellent way out of this often very trying self-criticism. The specialist need not see the futility of his reports, and may rest perched on his "eminent" pedestal; the doctor may grumble and feel justified in his contemptuous opinion of the useless and pretentious specialist, and no one need do anything. Our scheme, by bringing face to face as equals specialists and practitioners, has made this escape impossible. Admittedly we, as everyone else, have had cases in which very little or nothing could be done; this fact then had to be accepted explicitly and in full and open responsibility.

I have already mentioned another kind of escape, the establishment of a teaching-being-taught atmosphere. This temptation, although very attractive to both practitioners and psychiatrists, should in most cases be resisted. When listening to a case an experienced psychiatrist can almost always without any great effort make a "clever" diagnosis and even foretell with reasonable accuracy what will happen in the doctor–patient relation for the next period. If he indulges in such a "conjuring trick" he severely interferes with the doctor–patient relation and inhibits the doctor's powers of observation and ease of handling the case. The doctor will then try either to confirm the psychiatrist's prophecy or to prove it to be incorrect, according to the actual relation between them. In any case the individual doctor and the group are deprived of the opportunity of finding out for themselves the advantages or disadvantages of one or the other ways of handling the problem.

(c) Present Training Scheme

The weekly case conferences are the mainstay of our scheme. About 10–12 are held in each of the three terms. To secure intensive participation and, on the other hand, to obtain varied enough material, we found it advisable to have groups of six to eight doctors. In addition to the conferences we offer to any doctor who asks for it individual supervision of his cases—that is, about an hour a week of "private" discussion. While the conferences are taken by the leader of the course, the individual supervision is provided—aided by some external help—by other clinic consultants. Psychotherapeutic technique is highly individual. In order to avoid the danger of muddling the practitioner by the often widely diverging views and approaches of the various consultants, the supervisors were asked to attend some of the case conferences before taking on any doctor for supervision. It was explicitly stated that they were not expected to subordinate their individual views to those of the course leader; on the contrary, they were asked to take part in the case discussions as frankly as they wanted. The reason for their attendance was that they should acquaint themselves with the atmosphere of the conferences, and, on the other hand, that the doctors should have the opportunity of finding out who they would like to supervise their cases. As these supervisions are expected to run on well-known lines, I wish to restrict my report to the psychodynamics of the case conferences.

I have already pointed out that we try to avoid so far as possible the ever-tempting teaching-being-taught atmosphere. Our aim is to help the doctors to become more sensitive to what is going on, consciously or unconsciously, in the patient's mind when doctor and patient are together. This kind of listening is very different from "history-taking," and here we encountered much difficulty when trying to free the doctors from the automatic use of this kind of approach. The main difference is that history-taking is concerned almost exclusively with objective events or with events that can easily be expressed in words—that is, events towards which both doctor and patient can adopt a detached "scientifically objective" attitude. The events that are our concern are highly subjective and personal, often hardly conscious or even wholly beyond conscious control; also, as often as not, there exists no unequivocal way of describing them in words. Nevertheless these events exist, and, moreover, they profoundly influence one's attitude to life in general and still more so to falling and being ill, accepting medical help, etc.

"Automatic Patterns"

It may safely be said that these events, happening all the time in everybody's mind, are only partly sensible adaptations to the ever-changing environment; to a large extent they are governed by almost automatic patterns originating mainly in childhood but influenced by emotional experiences in later life. The first task for our scheme was to awaken in the doctors an awareness of these automatic patterns, and then to enable them to study more and more in detail how these patterns influence the patient's attitude towards his

own illness, and, on the other hand, how they colour or even determine his relations to any human being, and especially to his doctor.

Another factor affecting the patient's developing relation to his doctor is the doctor's response, which also is partly governed by automatic patterns. The interplay of these two sets of patterns, whether and how they "click" with each other, determines to a large extent the efficiency of any treatment. Its influence is less important in short-lived acute illnesses, but almost crucial in chronic ones. In order to achieve a better fit, and with more patients, the doctor must have a wide choice of responses, which means that he must become aware of his own automatic patterns and gradually acquire at least a modicum of freedom from them.

What is Needed

Intellectual teaching, however good and erudite, has hardly any effect on this process of liberation and general easing up. What is needed is an emotionally free and friendly atmosphere in which one can face the experience that quite often one's actual behaviour is entirely different from what has been intended and from what one has always believed it to be. The realization of this discrepancy between one's actual behaviour and one's intentions and beliefs is not an easy task. But if there is good cohesion between the doctors in the group, the mistakes, blind spots, and limitations of any individual member can be brought into the open and at least partially accepted by him. The group steadily develops a better understanding of its own problems, both collectively and individually. The individual can more easily face the realization of his mistakes when he feels that the group understands them and can identify with him in them, and when he can see that he is not the only one to make mistakes of this kind. Moreover, it takes only a very short time for the group to discover that the technique of each member, including the psychiatrist group leader, is an expression of his personality, and so, of course, are his habitual mistakes.

Admittedly crises occur from time to time, when one or other member finds it difficult to accept the full implications of some of his ways of handling his patients, or the realization of some facets of his personality that he had been only dimly aware of. These, however, can be borne, as they are also group events and do not solely concern the individual. It has been easy to describe this state of affairs, but it is rather difficult to explain its dynamism. So long as the mutual identifications of the members are fairly strong, any individual member can face strains because he feels accepted and supported by the group. His mistakes and failings, although humiliating, are not felt as singling him out as a useless member; quite on the contrary, he feels that he has helped the group to progress, using his failings as stepping-stones.* Crises may occur when there is some tension between one or the other member and the rest of the group which the leader has not detected soon enough (I would add that neither his role nor his psychiatric training confers on the group leader an absolute immunity against this hazard), and, instead of re-establishing good cohesion, his criticism may help to widen the gulf.

Signs of this isolation or tendency to isolation and the accompanying touchiness can be regarded as the equivalents of what psycho-analysis calls resistances. On the one hand, they are premonitory signs that some major personal attitude of the individual is being tackled in the group situation; on the other hand, by the way in which the isolation is achieved and maintained, they show what the problem is. In the same way the reaction of the integrated group towards such an attempt at isolation reveals the other side—that is, the counter-transferences of the group to the particular personality problem. The way in which a member isolates himself, as well as the way in which the group deals with it, must be shown up. They represent very valuable material for studying interpersonal relations, and their full realization is a necessary condition to the re-establishment of a workable cohesion.

If such crises occur too often, or leave a bitter resentment behind, it is a sign that the pace of training has been too exacting and that the group has been made to work under considerable strain for some time. It is an equally ominous sign, however, if no crises occur at all; it means that the sensitivity and grasp of the group are not developing, the group and its leader are in real danger of degenerating into a mutual admiration society where everything is fine and we are nice, clever, and sensible people. It is a fact that acquiring psychotherapeutic skill is tantamount to discovering some hard and not very pleasant facts about one's own limitations. This unpleasant strain must be faced, and the group develops as long as it can face up to it, and stops developing as soon as it tries to avoid it. It is the task of the group leader to create an atmosphere in which each member (including the leader) will be able to bear the brunt when it is his turn to bear it.

It is a precondition of our technique to establish this kind of atmosphere in the group, and it is only in such an atmosphere that it is possible to achieve what we term "the courage of one's own stupidity." This means that the doctor feels free to be himself with his patient—that is, to use all his past experiences and present skills without much inhibition. At the same time he is prepared to face severe objections by the group and occasionally even very searching criticism of what we call his "stupidity." Although every report and case conference is definitely a strain and an effort, the result is almost always a widening of one's individual possibilities and a better grasp of the problems.

Importance of Timing

One of the most important factors in this kind of training is timing, which in the first approach means not to be in a hurry. It is better to allow the doctor to make his mistakes, perhaps even to encourage him in this, than to try to prevent them. This sounds rather foolhardy, but it is not; all our trainees have had considerable clinical experience, and this "sink or swim" policy was justifiable. Apart from not undermining the confidence and dignity of the doctor, it has the added advantage of providing ample material for discussion, since everybody was seeing patients all the time and was anxious to report his findings and discoveries, his successes and difficulties. As I have confessed, this policy may have been too much for some doctors, and we had a fair number of "casualties" who did not wish to continue.

If the timing is good enough, the doctor feels free to be himself and will have "the courage of his own stupidity." Gradually he becomes aware of the type of situation in which he is likely to lose his sensitivity and ease of response, or, in other words, to behave automatically. Meanwhile the reports of the other doctors have shown him what other ways might be adopted in similar situations. The discussion of the various individual ways, demonstrating their advantages and limitations, encourages him to experiment. (One practitioner announced the result of such an experiment thus: "I have done a real 'Smith' in this case—and it worked," meaning he had adopted the attitude he felt Smith usually adopted.) Every such experiment means a step towards greater freedom and better skill.

Attitude of the Group Leader

Perhaps the most important factor is the behaviour of the leader in the group. It is hardly an exaggeration to say that if he finds the right attitude he will teach more by his example than by everything else taken together. After all, the technique we advocate is based on exactly the same sort of listening that we expect the doctors to acquire. By allowing everybody to be themselves, to have their say in their own way and in their own time, by watching for proper cues—that is, speaking only when something is *really* ex-

*In psychiatric terms, the depression caused by the realization of one's shortcomings must be fully accepted; identification with the common group ideal must remain, now as before, a desirable and attainable aim, but the group leader must watch very carefully when and how one or the other member is forced or allowed to slide into a paranoid position of the one who has been "singled out."

pected from him and making his point in a form which, instead of prescribing *the* right way, opens up possibilities for the doctors to discover by themselves *some* right way of dealing with the patient's problems, the leader can demonstrate in the "here and now" situation what he wants to teach.

Obviously no one can live up to these exacting standards without some shortcomings. Fortunately there is no need for perfection. The group leader may make mistakes—in fact, he does quite often—without causing much harm if he can accept criticism on the same, or even somewhat sharper, terms as he expects his group to accept. This must be watched very carefully, and any hesitation by the group in exposing the leader's mistakes must be pointed out. Obviously this freedom cannot develop if the leader tries to hedge or to explain away his failings. It is a very wholesome sign if the group can run the leader down, even if they have some fun at his expense, if only they can do so without rejecting him or turning hostile to him. (Incidentally, this frank criticism is another way in which practitioners can teach us specialists.)

The Training Technique

One more word about the number of doctors who dropped out. The technique described here is still in its experimental stages—that is, it is crude and harsh. We are fully aware of this and we have decided to accept the risks involved. Our first consideration has been to develop a technique that is workable for a fair enough proportion of the doctors interested, in order to test out whether such a training technique is possible at all. The results of the two pilot projects —the Family Discussion Bureaux scheme for social workers and the Tavistock Clinic scheme for general practitioners —are highly encouraging, although as yet not final. As soon as our technique is fairly securely settled, our next concern will be to examine our "casualties"—that is, the reasons why so many of our entrants have to leave us. It is true that psychotherapy in the same way as, for instance, surgery, is not within everybody's reach; nevertheless our "casualty rate" is too high. Conversely, this means that our training technique is, for the time being, inelastic and too exacting for a great number of practitioners.

There is, however, one very important difference between this kind of training and any other training in one or other of the many specialties in medicine. Any advance in therapy demands a new skill from the doctor, even if it amounts only to learning the correct ways of prescribing a new drug. In other words, mastering a new therapy means a change. But, whereas the changes required by new techniques in any of the other branches of medicine do not touch much upon the doctor's personality, the technique of psychotherapy involves the personality fairly deeply. From this angle the action of some doctors who dropped out is perhaps a sensible defence against an unauthorized violation of their private mental life, a defence that must be treated with respect. The diametrically opposite danger is that the group training may degenerate into therapy pure and simple. We are fully aware of this possible complication, which, in fact, is present in every form of psychiatric training, but as our scheme is a very young one we have not had to come up against it.

Summary

A training scheme in psychotherapy is described, in which the emphasis has been put on acquiring a personal skill instead of on teaching. The aim is to make the general practitioners aware of what their patient wants to convey to them, not so much by his words as by his whole behaviour, and of how their own general behaviour and actual responses influence what the patient can actually tell them. We have tried *not* to teach them what psycho-analytic or any other theory could say about the working of the human mind; instead we have aimed at enabling them to be free enough to feel and understand what is going on between the patient and themselves in their surgery.

APPENDIX

It is generally recognized that it is rather difficult to describe in a condensed and concise form the subtle work of psychotherapy in any given case. That is the reason why only two case histories are given here as illustrations. The first describes the events and the consequences of what we called "the collusion of anonymity" between the general practitioner and his consultants. The second case tries to give an impression of the stage to which psychotherapeutic skill and understanding of our course have developed. When judging the case history, the reader must bear in mind that the work reported here was done in the third month of a course which is planned to last two years. Both case histories were compiled by the doctor treating the patients. Since, according to our idea, the doctor's personality plays also an important part in every therapy, I start each case with a short characterization of the doctor in charge.

Case 1

The doctor attending this case works in a partnership. His partner is a straightforward practitioner who wants to get on with the job. The reporter, however, is interested in the psychological implications of the illnesses and has a fair knowledge of the current psychiatric ideas. He reports:

"A married childless woman aged 32 has been on my partner's list since 1946. She complained then of epigastric and chest pains. In April, 1946, my partner sent her for investigation to an eminent physician, who reported: 'You will be glad to hear that this patient's chest *x*-ray film is quite normal. She seems very pleased at this, and I think most of her symptoms are functional, and I hope that the reassurance that I have given her may be of some help.' A short while after this the patient was unhappy about the condition of the chest, as the pain returned, and she was sent for *x*-ray examination to a chest clinic. The physician to the chest clinic reported in May, 1946: 'You will be pleased to learn that there is no evidence of pulmonary or pleural tuberculosis. I think the epigastric pain originates in the abdominal wall—that is, it is probably muscular or fibrous in origin. Massage might now be tried.' Massage was accordingly tried, but with little success.

"She was a frequent visitor to the surgery, and was seen by me first in October, 1946. I thought then that her symptoms might be due to 'chronic appendicitis.' I referred her to a gynaecologist first, who wrote in 1947: 'This lady is rather puzzling. She has been under Dr. L., who had her completely investigated and found nothing; I must admit I can find nothing abnormal, and from the gynaecological point of view I have drawn a blank. Whether in view of her constant pain in the right side and her chronic constipation there is the possibility of appendix trouble, it is difficult to say, but if you wish I will ask one of the surgeons, etc.' A surgeon was accordingly asked, and he said, in October, 1947: '. . . I have advised her to come into hospital for the removal of the appendix.' Appendicectomy was carried out in December, 1947. She came to see me practically every week with a variety of pains, sometimes in the right iliac fossa, sometimes in the back, and drove me frantic with seemingly irrelevant chatter and unwillingness to leave me during a busy surgery. I sent her to see a well-known orthopaedic surgeon on account of her persistent backache. He said in January, 1948: 'She has a supple back, although there is some slight tenderness in her lumbar muscles. I am arranging for her to have some treatment in the physiotherapy department.'

"She attended my surgery every week regularly, had still the same complaints as before, and began, to my puzzlement, to be rather aggressively flirtatious with me. I then told her one day, rather abruptly, that there was little more I could do for her and that it would be best if she went back to her job as a sales assistant and not come back to see me for some time. I did not see her again until 1950. She came then with her old complaints of pains again and in the attitude of a penitent child ('Didn't you miss me,' and 'I hope you won't be cross with me any more'). She still came every week, again became flirtatious and tried to put her foot on mine, and one day put her hand on mine. I

rebuked her, and she cried. She came back the following week and in subsequent weeks, receiving five to ten minutes' chat and a bottle of medicine on each occasion.

"Since then, owing to a greater awareness of personality disorders on my part, she has been given a one-hour interview in which, *inter alia*, she told of her childhood, of a father who was in the Navy and away from home most of the time, of a much-loved younger brother who died at the time of the onset of her symptoms, of her dyspareunia since the beginning of her marriage, and her complete inability to have sexual intercourse since her brother's death. Further investigations are in progress. Her attitude to me since that interview has much changed; there are no more efforts to flirt and there is an improvement in her symptoms. But it took four years to get that hour, and an appendicectomy. *Mea culpa!*"

Case 2

The doctor in charge of this case is a well-experienced and rather cautious general practitioner. Although he seemed to be sincerely interested in his patients' psychological problems he was careful, until coming to the course, not to get too much involved with them. He attended for three terms, hardly missed a conference, and, although following the discussions with great interest, even to quoting his own experiences, never tried any real psychotherapy with his patients. Then suddenly he decided to start with one case, and on the same day the case of which the following is his report occurred in his practice. It was this case which he started reporting with the phrase, "I did a real Smith—and it worked."

"The patient, a boiler coverer, aged 26, was a quiet, thin, pale, neat, inoffensive young fellow. Married three weeks before. Severe headaches. No relief in tab. codein. Pain 'behind eyes'; feels 'something wrong with brain.' Cannot go to sleep, and wife has to sit with him and hold his hand. Worries about 'floods.' For the last two months he could not go to the cinema; he gets lost in the film and suddenly 'comes to,' gets a 'crowded-in feeling,' feels panicky, screen seems to recede, and he has to rush out of the cinema. He also fears boilers now and is jumpy when working on them. He has always found it hard to make friends and is content to be by himself.

"No sex life before marriage. Satisfactory now for him, but wife has to be manually masturbated to achieve orgasm. ('I feel funny telling you that.') Feels content sitting in in-laws' house now, in spite of noise of numerous children, but is not so happy about going out. His wife has recently recovered from pulmonary tuberculosis and is at work again. The patient is very 'fussy'; does all the housework himself because he likes to do it, not of necessity. Gets a 'kick' out of giving his wife breakfast in bed.

"*Family History.*—Mother died when he was 3 years old, and he and his two elder brothers were sent to an orphanage, where he stayed until 14. Father had tabes and was blind. When the patient left the orphanage he became the maid-of-all-work at home. It was he who did the shopping and cooking and cleaning. He led his father about all the time, not his brothers. (This I remember very well, as I used to treat his father and knew the family set-up well.) His only hobby was motor-cycling, and he always took his father out on the motor-cycle. He thinks his father's blindness was due to war injuries and experiences. He himself often wondered what it was like to be blind, and often did a 'silly thing'—drove his motor-cycle blind to see what it felt like. His father's mother was blind (he was told) and she was also the youngest in her family.

"He dislikes his elder brother intensely and the dislike is reciprocated. This brother always acted the big boss: he expected to be waited on, 'took everything for granted,' and expected the patient to wait on him like a slave. The brother does not drink nor smoke, and is a highly critical sort of chap. He even supervised the patient's courtship, told him when he should get home at night, and strongly advised him against marriage. The brother's marriage broke up after three weeks and was 'annulled' (that was the word he had heard used.) The patient was afraid of him, but now they are not on speaking terms and pass each other in the street.

"Two weeks ago the patient was admitted to hospital for investigation because of the severity of the headaches: He was discharged after a few days, being told it was his 'nerves.'

"*Hospital Notes* (seen by me).—'Came to hospital in taxi as he could not walk owing to severity of headaches. Admitted: ? sinusitis; ? migraine. Investigated, and no organic cause found. C.N.S. clear. Discharged. To be seen again next week. ? Psychiatrist.'

"March 13, 1953.—He reported to me immediately after he left hospital, complaining that headaches were still persistent and that he could not get to sleep. 'I don't know why I should be like this; after all, it is the first time in my life I have been free from financial worry—for example, paying off motor-cycle—and wife is over her T.B. and is working. Thus I can have little luxuries I could not afford before.'

"*Immediate Interpretation After Taking History.**—Assured not organic and nothing to do with father's blindness. 'You have always been pushed around since childhood and always in an inferior position. The Cinderella of the family. You had no right to be all right. You always had to carry a burden and had no right to affection (which you really craved). Now you are suddenly free of your tasks (through which you were playing out your inferior position) and you are immediately obsessed with guilt. So you have to atone with a symptom—the obvious one being headache—behind eyes—associating yourself with your father, to whom you were attached (and perhaps unconsciously resented).' 'I thought of that myself.'

"March 16.—Saw the patient again. He said he felt 'marvellous.' No headaches; knows it is not organic now and understands symptoms are due to his previous life; sleeps through the night and goes off to sleep immediately; not frightened in a crowd, and is very grateful.

"May 7.—The patient has been back at work since March, is very happy with his wife, sleeps well, and has no complaints at all."

Postscript when reading the proofs.—Report of the practitioner on October 22: "Man not seen for several months, only wife, who reported that he was fine. He occasionally gets headaches, which do not amount to anything, and he continues working. He is much easier to live with, and from the point of view of the wife he is a complete cure."

*This interpretation was what the doctor described as: "I did a real Smith."

MYELOMATA OF BONE

A REVIEW OF 25 CASES

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Myelomata are said to be the rarest form of bone tumour (Geschickter and Copeland, 1936; Cade *et al.*, 1947), yet of 25 cases here reported 24 have been treated in this hospital group over the past five years, and one of us (A. N.) has had nine under his care in the past two years. During this same five-year period 13 cases of osteogenic sarcomata of bone (including three cases arising in Paget's disease) have been treated in the Bradford Regional Radium Institute. Osteogenic sarcoma is given considerable prominence in medical textbooks, yet it is apparent that its incidence is less than that of myelomata of bone. We suspect the incidence of the latter is not so uncommon as is usually suggested, and believe that many cases are wrongly diagnosed as secondary carcinomata or never diagnosed. Four cases in this series were diagnosed only when the patient was admitted *in extremis*. One is apt to associate myelomata with the textbook picture of multiple discrete osteolytic lesions in the skull, clavicle, vertebrae, and ribs, but this is usually the terminal picture. Hence one finds that most cases have a history lasting one to two years before the diagnosis is made. Early diagnosis is difficult because the condition is often asymptomatic for a long period, while signs and bio-